EXHIBIT D

In The Matter Of:

Misty Blanchette Porter, MD v.
Dartmouth-Hitchcock Medical Center, et al.

Heather Gunnell
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UNITED STATES DISTRICT COURT
DISTRICT OF VERMONT
Case No. 5:17-cv-194

MISTY BLANCHETTE PORTER, MD,
Plaintiff
vs.
DARTMOUTH-HITCHCOCK MEDICAL CENTER, DARTMOUTH-HITCHCOCK CLINIC, MARY HITCHCOCK MEMORIAL HOSPITAL, and DARTMOUTH-HITCHCOCK HEALTH,
Defendants

D E P O S I T I O N
of
HEATHER GUNNELL
Volume I

Taken at the law offices of Vitt & Associates, PLC, 8 Beaver Meadow Road, Norwich, Vermont on Friday, August 2, 2019 commencing at 10:00 a.m. before Sunnie Donath, RPR

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Also Present: Misty Blanchette Porter, MD

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STIPULATIONS

It is hereby stipulated and agreed by and between the attorneys of record for the respective parties hereto as follows:

1. That the testimony of HEATHER GUNNELL may be taken pursuant to the Federal Rules of Civil Procedure, and treated as if taken pursuant to notice and order to take depositions and that all formalities of notice and order are waived by the parties, and the signatures to the stipulation are in like manner waived;

2. That all objections except as to matters of form are reserved until the deposition or any part thereof is offered in evidence;

3. That the deposition may be signed by the said HEATHER GUNNELL before any notary public.

* * * * *

of years.
Q. How did you know how to handle the job? It sounds like it was, it was a little bit different from what you had done previously. When you showed up as the practice manager, how did you get trained? What did you, what did you do to learn how to fill the job?
A. The, I'm, I'm chuckling because it's a long process. Yes, there was a fair amount of training. Karen had put together a, you know, really comprehensive, You need to meet with all of these people and go through this. I did a lot of listening. I met with everyone who would meet with me to talk to them. I went through some Lean Six Sigma training to be able to learn how to do that better. But I, I had a long history of management and program management, and I did not go into that job completely green.
Q. What is Lean Six Sigma?
A. It's a process improvement methodology.
Q. Do you know anything about the origins of Lean Six Sigma?
A. I, I can't recall all those details right now.
Q. Do you remember -- what do you remember from that training?
A. I remember a lot of focus on the, the process of trying to ascertain and come to a root cause, the

process of gathering data and including your team and change management. It's a very comprehensive. It was about a year process that I went through.
Q. A year of training?
A. Yes.
Q. Is that a continual process? Have you done more Lean Six Sigma training since the beginning?
A. No.
Q. And is that a, a management philosophy that's embraced by the institution overall?
A. That's correct.
ATTORNEY KRAMER: Is it okay to take a quick break?
(A recess was taken from 10:50 a.m. to 11:04 a.m.)
BY ATTORNEY KRAMER:
Q. You had testified earlier that you exchanged text messages with Regan Tyler?
A. Yes.
Q. Who is Regan Tyler?
A. She was the division director for the generalist division.
Q. How long did you work with Dr. Tyler?
A. I don't remember exactly when she left, but three to four years.
Q. Why did you exchange text messages with her?

A. I don't know. We would, we would get together about once a year to celebrate our new work, like, our work anniversary, and we were friendly.
Q. Why her and not the other providers in the department?
A. I don't know.
Q. Was there something different about your relationship with her?
A. I got along quite well with Dr. Tyler.
Q. Why do you think that is?
A. Our personalities clicked. We started at the same time, and so we were both trying to figure out and navigate the Dartmouth-Hitchcock system together, and I worked with her a lot with her division.
Q. Did you exchange text messages with any of the other providers?
A. Probably occasionally but nothing of note. The similar type of running late for a meeting, etc.
Q. Do you give out your cell phone number to work colleagues?
A. Yes.
Q. Why is that?
A. So that they can reach me when they need me.
Q. Let's, let's focus on 2014 when Dr. Hsu, Albert Hsu, joined REI.

A. Okay.
Q. Who is Dr. Hsu?
A. Dr. Hsu was an REI provider who came on board the REI division right after his fellowship.
Q. And do you remember when it was that you first met Dr. Hsu?
A. I met him when he started working at Dartmouth-Hitchcock.
Q. I believe that was at some point in 2014. Do you remember when specifically?
A. I don't remember when specifically.
Q. What was your initial impression of Dr. Hsu?
A. He seemed like a very nice guy.
Q. Anything else?
A. No.
Q. Did your impression of him change over time?
A. Yes.
Q. How so?
A. The more I got to know Albert, the more, Dr. Hsu, the more I realized that he took a fair amount of managing.
Q. What sort of managing?
A. He was very high need and very -- he communicated a lot, so it would take a lot of conversations with him to suss out what he needed from me and what we could do

whatever actions that team of people decided were necessary.

(Deposition Exhibit 2 marked.)

Q. Let me show you -- this will marked as Exhibit 2. This has been -- did you have a chance to read it?

A. Um-hum.

Q. Yes?

A. Yes. Well, I was finishing. Yes, I have read this.

Q. Okay. So this has been marked as Gunnell Exhibit 2, DH26525 and 26. It's an email chain regarding an issue with a patient, MK. The top email is Dr. Hsu sending this to you. Having reviewed this email chain, what's your understanding of why Dr. Hsu was sending this to you?

A. I know he had spoken to me in person about this patient, and it, so I think he was sending this to me to just loop me into the broader conversation he was having.

Q. What did you understand the situation to be?

A. At this point, I don't remember exactly.

Q. I have another document I'll show you in just a sec that may explain it a little more. We'll see. It says here in the middle of the page, there's an email from Navid Esfandiari to Dr. Hsu and Sharon Parent

where Navid says, "The confusion was due to lack of documentation in BBS". What is BBS?

A. BabySentry. It is the REI-specific electronic medical record that the REI division and the lab used.

Q. And what's your understanding of who was responsible for the lack of documentation?

A. In this particular instance, I do not know.

Q. Do you know if it was Dr. Hsu?

A. I don't know.

Q. And let's mark this as Exhibit 3. Let me know when you've had a chance to review it.

(Deposition Exhibit 3 marked.)

A. Okay, okay.

Q. Okay. So this is an email chain from May 13th 2016, which is around the same time period as the documents we were looking at in Exhibit 2 --

A. Um-hum.

Q. -- DH26723 and 24. In this email chain, it starts with Albert Hsu emailing you and Karen Boedtker about a situation involving patient MK, and it says that you and Heather -- it says that, "Heather and I had the opportunity to meet with the patient yesterday".

Do you recall that, that situation of meeting with a patient with Dr. Hsu?

A. Yes.

Q. What do you recall?

A. I recall late that afternoon Albert coming down to my office to see if I had time to meet with this patient who was very upset. I recall going into the room and listening to the patient and her husband talk to me about their dissatisfaction with the, with the communication from the division at that point. I recall them saying that there were some specific people in that division that they did not want to receive care from any further, and I remember talking to them about trying to understand what they were comfortable with moving forward.

Q. How common was it for you to meet directly with patients?

A. It was not uncommon when there were patient complaints. It was uncommon for a provider to come get me and bring me down to the exam room to meet with a patient.

Q. And in this situation Dr. Hsu came to get you?

A. Yes.

Q. Why did he come get you?

A. The, the patient and her husband were incredibly upset and wanted to be able to talk to somebody.

Q. Looking at the, the second page of this, Dr. Hsu says that he is thinking of emailing both of you,

meaning you and Karen Boedtker, with a draft of the note that he would put into the medical records. Is that an unusual thing to do?

A. Yes.

Q. Do you think that's an appropriate thing to do or inappropriate?

A. I don't know. This was a pretty unusual situation where he wasn't -- typically, it's not appropriate for a practice manager to be consulted on a clinical note. In this situation, because it was primarily a patient complaint, he seemed to think that he wanted some, some extra eyes on it. It's not something I typically do.

Q. And, in this email at the, at the top of Exhibit 3, you say that you were going to make a similar change to the language. My interpretation of this is that you were, you were therefore involved in crafting the language that would go into the note.

A. I was not involved in crafting the language. I remember wanting to make sure that the providers who they were complaining about not be named in that clinical note and that, if there was going to be a complaint about providers, that that go through risk or patient relations rather than in the medical record.

Q. You mentioned that these patients did not want to be treated by certain providers. Which providers?

A. They did not want to be treated by the nurse, Sharon Parent, and they did not want to see Dr. Porter, and they also had complaints about Elizabeth Todd, if I remember correctly.
Q. What were their complaints about Dr. Porter?
A. I don't remember specifically.
Q. Do you remember generally?
A. I remember generally they didn't like the way they were treated, not necessarily clinically, but the interpersonal dynamic.
Q. Who is Karen Boedtker?
A. Karen Boedtker is one of the employees in risk management.
Q. How often did you communicate with Karen Boedtker?
A. In the -- it would ebb and flow. Sometimes it was a couple of times a month. Sometimes I'd go several months without communicating with her.
Q. And what is the role of risk management at Dartmouth-Hitchcock?
A. Can you ask -- are you looking for my impression of the role of risk management? I mean, they're responsible for a lot of legal things that I'm simply not aware of.
Q. Your understanding of what's, what's their role?
A. Right. So my understanding is that their role is

to help us make sure that we appropriately deal with any sort of complications or, or issues around patient complaints or any sort of clinical, clinical complications. So my, my interaction with them was typically with patient complaints or if one of our providers would say, Hey, I'm going to give risk management a heads up because of something that happened with a patient's care.
Q. Did you ever take issues to risk management?
A. Just myself?
Q. Yes. Based on something that you saw or heard about or understood to be going on.
A. I don't remember. I don't remember if there were situations where it was just me going or if it was just me working with the, the group that was brought forward.
Q. And did you talk with anybody about, at risk management, about issues in the REI division?
A. Yes.
Q. Who did you speak to?
A. I worked with Karen Boedtker quite a bit. I worked with Michele King also, and then some other people in patient relations. I don't remember his name.
Q. Did you speak with them about specific issues, or

did you ever speak about the general dysfunction of the division?
A. Both.
Q. Talking first about the general dysfunction, what was the nature of those conversations?
A. The nature of those conversations was typically in the context of one of the patient complaints. But so we'd get a complaint, and we'd be talking about that, and then I'd be able to say, but, generally, it's, it's not likely I'm going to be able to ask these nurses to communicate differently, because they simply won't. You know, there's a level of dysfunction here that is beyond my ability to change people's personalities, and so my responsibility working with risk management was to help them understand the context of the situation as well.
Q. What response did you get from risk management when you brought up these issues of what you perceived as the general dysfunction of the division?
A. I don't remember.
Q. Do you remember generally what they said?
A. I remember generally that they were trying as hard as I was to try to deal with these patient complaints and that there was sort of a general disheartening among all of us that, that we kept having to have these

phone calls.
Q. Over what period of time did you bring complaints to risk management?
A. I don't remember.
Q. Was it throughout the whole time that there was the REI division?
A. It was probably a two- to three-year period. There were periods of time when I first started where I would hear from Dr. Porter or one of the nurses that they were going to fire a patient and that they were working with, with risk management, and so I may or may not be involved in taking a look at that as well.
Q. Were there any patient safety concerns that you brought to risk management?
A. Not that I remember.
Q. Do you know if anybody else brought patient safety concerns to risk management regarding the REI division?
A. I don't know.
Q. What was your impression of the relationship between Dr. Hsu and Karen Boedtker?
A. I don't know.
Q. Did you see them interact?
A. No, not that I remember, no.
Q. Did you ever observe them talking to each other or about each other?

A. No.
Q. For the patient complaints that you handled that went to risk management related to REI, which of the physicians within REI were they about?
A. All of them.
Q. What was the distribution?
A. I don't remember. The, the vast majority of the complaints from patients were more global about the, the dysfunction and the breakdown in communication among the team. So a lot of complaints had to do with the feeling that patients had that the providers and the nurses simply were not communicating with one another about their plan of care. I would receive complaints that, you know, Dr. Hsu gave me X plan, but then, when I talked to Dr. Porter two days later, she gave me a different plan. Which plan am I on? No one's talking to me. So those type of complaints.
Q. How frequently did something like that happen where a patient felt that they were getting conflicting information from different providers?
A. That escalated, and so those type of complaints became more frequent in the year or so -- well, the timeline's broken up in my mind, because I was on maternity leave for a little while, but for, you know, a year-and-a-half or so prior to the closing, those

type of complaints became more frequent.
Q. Why do you think they became more frequent?
A. Because the team was dysfunctional and would not communicate with one another, so patients would call to complain more.
Q. Did the team get more dysfunctional over time?
A. Yes.
Q. Did it get more dysfunctional when David Seifer came on board?
A. Yes.
Q. We'll talk about David Seifer in a little bit. Going back to Dr. Hsu, what was your understanding of what procedures Dr. Hsu could perform?
A. I don't remember specifics. I do remember that he was not a full-scope surgeon in the same way that Dr. Porter was.
Q. What do you mean by full-scope surgeon?
A. So Dr. Porter did quite a bit more GYN surgery than Dr. Hsu did, and my understanding is that Dr. Hsu stayed much tighter to just a, like an REI provider, whereas Dr. Porter did, did more of those cases.
Q. Was Dr. Hsu able to read ultrasounds?
A. He did read ultrasounds, yes.
Q. Did you have any understanding of his level of competency in reading ultrasounds?

A. No. Again, the clinical piece of it was beyond my, my scope of management.
Q. Did you have any either responsibility or oversight for assigning patients to certain providers' schedules?
A. No.
Q. Who had that responsibility?
A. So the providers would work with the scheduling secretaries to, to map out who would be where, and then the scheduling secretaries would book the patients into those patient slots, and ultrasound was included in that.
Q. Did you have any knowledge about Dr. Hsu's pregnancy rates?
A. Not really, but I did see some data at one point that I believe was sent from Navid about what the pregnancy rates for the division were.
Q. Do you remember when that was?
A. I don't remember. I don't remember if it was right before Dr. Seifer started or shortly after.
Q. Did you receive regular, maybe annual or semiannual, reports about the pregnancy rates coming out of REI?
A. I did not receive any reports from the BabySentry system, which is where that would be held. I would

hear anecdotally about, about the pregnancy rates, but that was not a data point that came across my desk regularly.
Q. Do you know why it wasn't?
A. I don't know why.
Q. It seems, it seems important to the functionality of REI. I'm surprised that that information didn't come to you. Did you go looking for it?
A. Looking for the pregnancy rates?
Q. Yes.
A. No.
Q. Why not?
A. Because, again, the, the clinical piece of that, we have division directors, we had a chair, we had the lab director. All of those people paid attention to that. That was part of the clinical piece that they were responsible for, and I was primarily responsible for the operations and the finances.
Q. What did you hear anecdotally about Dr. Hsu's pregnancy rates?
A. It depended on who I was talking to. So I would hear from some people like Dr. Porter that they were low, but then I would also hear from Dr. DeMars that they were actually fairly normal, and so, having not seen the data, I wasn't quite sure where that actually

around that.
Q. Did you hear concerns about whether Dr. Hsu was managing those issues appropriately?
A. I don't remember.
Q. How about with Dr. Seifer?
A. I don't remember.
Q. Who is Beth Todd?
A. Beth Todd was the nurse practitioner assigned to the REI division.
Q. And did she work primarily in REI?
A. Yes.
Q. What makes you say that?
A. Because she worked primarily with REI and did some GYN care as well.
Q. How much GYN care did she do?
A. I don't know the exact distribution.
Q. What was the scope of her practice?
A. I know she worked with -- she did some general GYN care. She worked with the REI providers, did IUIs. I'm not sure exactly what you're asking me.
Q. It sounds like that may get into more of the clinical side, which is outside the range of what it sounds like you're familiar with. Is that, is that true?
A. Yeah. Yes.

Q. All right. So we're going to fast-forward a bit, and I think we will, we'll rewind later, but I would like to now move to the period of time in mid to late April 2017 around the time that discussions about what to do with REI were really heating up. What was happening in the REI division in April 2017?
A. I'm, I'm trying to remember, because there was so much that happened in that division in that, like, six-, eight-month time period. I believe --
Q. What -- sorry. What six- to eight-month time period are you talking about, the six to eight months before the closure?
A. That's correct.
Q. Okay.
A. I believe in April is when we found ourselves losing the last fully trained REI nurse. I don't remember exactly when she gave her notice, but I believe that timeframe was when we were looking at significant staffing issues.
Q. Was that Marlene in Bedford?
A. That's correct.
Q. Would you be able to give me a, a high-level, fairly brief overview of what was happening in that six- to eight-month time period, understanding that we'll come back and sort of drill down? But I think

that might be useful for setting some context.
A. Okay.
Q. Can you do that?
A. Yes. So, so, generally, I don't remember the exact timeframe, but that six- to eight-months timeframe we were working with the Value Institute and some other teams in Dartmouth-Hitchcock to bring the group together to work on the interpersonal dynamics, the communication, and more broadly the various work flows and, and paths for managing patients so that there was some consistency.
The idea was to try to address the, the many complaints both from patients and staff within that division to try to bring this together. So we were doing that more globally. We were also looking at some pretty significant staffing concerns among, with the nursing, trying to keep enough nurses to provide the care safely and keep the division running.
Q. What were the discussions that you were having with anybody at that time about what to do with REI?
A. At that time, the real focus was on we just want to shore this team up. We need to, we need to figure out the, the dysfunction. We need to get them to communicate together. Let's give all of the resources that we have available to us to see if we can bring

this group together and make this work.
Q. What time period was that?
A. I think we started the conversations with the Value Institute in the fall, maybe late fall of 2016. There were a couple of retreats. I believe there was one in January, February. It was an ongoing process with some really dedicated time off site. I don't remember the exact dates of that, though.
Q. At some point, was there a working group put together to figure out what to do with REI?
A. What do you mean, a working group?
Q. Maybe that's not the right term, but a smaller group of people who, including you, who were tasked with figuring out what was happening to REI?
A. I don't know that there was really a group put together for that. I mean, I certainly brought my concerns to Dr. DeMars and said, "I think we should reach out to the Value Institute. I think we need to put this group together". I worked directly with many of those people to, to prepare for those retreats, to pull together documents, but it wasn't necessarily a formally formed group, if that makes sense.
(Deposition Exhibit 5 marked.)
Q. I think so. This has been marked as Gunnell 5. Let me know when you're ready.

A. Okay. I'm ready.
Q. So this is Gunnell Exhibit 5, DH9582 and a number of pages after that in attachment to this email. This, the cover page is emails back and forth between you, Daniel Herrick, and Leslie DeMars. Looking at this email and the attachment, does this refresh your memory about some of the conversations in this time period? This email is dated April 19th 2017, and, before we get into the specifics of this, I'm wondering if you could explain to me more of the context of what was going on at this time period.
A. Yes, this, this helps me remember this particular time period. So, best of my recollection, at this point the decision had been made to close the division, and so I was working with Daniel on, on that process.
Q. When you say "the decision had been made", who made the decision?
A. My understanding is that Dr. Merrens made that decision.
Q. What do you know about the discussions that led to that decision?
A. I wasn't involved in the discussions about closing, closing the division. So my understanding is that there were several conversations, particularly after the end of the Value Institute work, between

Daniel Herrick and Dr. DeMars and that, and that they, there was a recommendation given to senior leadership, including Dr. Merrens.
Q. A recommendation by whom?
A. I believe that Daniel Herrick recommended, after the last nurse left, that, that the program be closed down.
Q. When did the last nurse leave?
A. I don't remember exactly.
Q. Was Marti Lewis still in the division at the time it shut down?
A. Yes, she was.
Q. And, when you say "last nurse", do you, are you referring to Marti, or are you talking about somebody else?
A. I should clarify. The last fully trained nurse for the division, who was Marlene in the south.
Q. How do you know that it was Ed Merrens who made the decision to close REI?
A. I've heard him say that it was his decision.
Q. When did you hear him say that?
A. As the, after the program -- I've heard him say it on several occasions, and that's how, that's how -- that's why that's my understanding.
Q. What information was given to Ed Merrens to make

that decision?
A. I don't know.
Q. Did you provide information? Did you provide any information directly to Dr. Merrens?
A. Not directly to Dr. Merrens.
Q. How about indirectly?
A. I provided information to Daniel.
Q. What information did you give to Daniel?
A. Anything that he asked for. So some of it is right in here.
(Indicating Exhibit 5.)
Q. What did he ask for?
A. So I don't remember all of the details. I remember being asked to provide an ROI.
Q. What's an ROI?
A. A return on investment, so the financial data around the REI division, working with our financial analyst at the time.
Q. How would one calculate a return on investment for a clinical division?
A. So finance would take a look at all of the expenses and all of the incoming revenue around a division and put together a financial package for that.
Q. Is it your understanding that the financial picture around REI was a part of the decision about

whether to keep REI open?
A. My understanding is that that was not part of the decision.
Q. What other information did you give to Daniel Herrick?
A. At what point?
Q. What are the different points that you're thinking of?
A. So I, I know that I tried to keep him up-to-date. He was, he was fairly remote during the Value Institute process, so I would let him know we're doing X, Y, Z retreat for the group. I did communicate to him when Marlene gave her notice that I was concerned that we were down to having no fully trained nurses in that division, and then, when he would request information from me, I would, I would give it to him.
Q. Other than the financial information, what did you give him?
A. I don't remember all of that. I don't remember all the details.
Q. Did Daniel Herrick ever come down and speak with the providers?
ATTORNEY JOSEPH: That's speculation. You can answer.

Q. Did she want to save Dr. Porter's job?
A. I suspect so. I don't know.
Q. In the conversations with Dr. DeMars about different options for the REI division, did at least some of those variations include retaining Dr. Porter as an employee of Dartmouth-Hitchcock?
A. Yes, yes.
Q. Did any of those variations include terminating Dr. Seifer and Dr. Hsu only?
A. I don't remember Dr. DeMars talking specifically about terminating anybody.
Q. Do you remember her talking generally about moving some people out, something other than as strong a word as "terminate", but maybe something, a looser idea?
A. My conversations with Dr. DeMars about this process felt very much -- my impression of them was very much that she was in denial that the, that the division needed to be closed and, instead, was searching for ways to try to keep things going.
Q. What did you understand your role to be in that process?
A. In which process?
Q. The process of figuring out what to do with REI.
A. I understood very clearly that it was not my, I had no authority to make that decision, and so, during

those conversations, it was, it was my responsibility to sort of talk to her and look at the reality of the situation.
Q. It sounds to me like you have a, you had a clear feeling of what should be done. What was your feeling about what should have, what should be done with REI in that period of late April 2017?
A. I, it was complicated. I, I did not actually expect us to get to a place. I kept wanting to try to find a way for us to keep going. When the last nurse gave her notice, I wasn't sure how we were going to do that.
Q. How you were going to keep going?
A. How we were going to keep the division functioning and be able to provide safe care for the patients, and I was very concerned that the team did not have a realistic view of just how dire that situation was.
Q. What team are you referring to?
A. I'm referring to the REI providers and Dr. DeMars.
Q. What did you hear from the providers about their perspective on what was going on?
A. I often heard various suggestions on how to get nursing staff that were not particularly realistic, and, and I did not hear any of them really understand just how complicated the situation was or really

understand just how tenuous the situation in the division was.
Q. Why did you think the proposals for getting nursing staff were not realistic?
A. Well, it depends on the proposal. So, for example, one of them was, We can just take some procedure nurses from New London Hospital and, and bring them in and have them help with this, and it, it's not realistic to be able to do that in a week. So some of the suggestions were simply not realistic to be able to do in the timeframe necessary, and it was also incredibly difficult for us to hire qualified nurses. REI nurses are difficult to find trained, and there was a nursing shortage throughout the institution, and REI had a reputation for not being a great place for nurses to work. So it was a very complicated dynamic.
Q. I'm surprised by your statement that the, the providers in REI were in denial of how dire the situation was, because they were the ones living it day-to-day. Can you explain more why you thought the providers who were living this day-to-day were in denial about the reality of the situation?
A. So the situation I'm speaking about in particular was the reality of how, how difficult it is to hire and train nurses. So I suspect that they knew things were

difficult, but they did not seem to have a real understanding of why it was difficult to bring nurses in and did not seem to understand why I couldn't just make it happen in two days. So that's the, that's the situation specifically that I'm talking about.
Q. As of April 2017, what efforts were being made to recruit nurses to REI?
A. As of April, at this point? So we had open positions. We had been interviewing people. We had been looking into per diems. HR, at the end of the Value Institute process and that team dynamic, we were told by -- we meaning Dr. DeMars, Dr. Seifer, Daniel Herrick, and I -- were told that, with the nursing shortage in the institution and very clearly that the team was not coming together, HR would not actively help us recruit for our nursing positions when there were so many other positions open.
Q. And that was February 2017?
A. I don't remember exactly when that was.
Q. If I'm understanding this correctly then, from approximately February 2017 until the closure, there was no authorization to hire nurses into the REI division?
A. I don't know that there was a very clear, like, drop-off. We had active positions, and, when we had

candidates, we would call them in, and we were doing our best, but it was very clear from HR that, unless that dynamic could be fixed, they would not make us a priority.
Q. How hard is it to train an otherwise competent and skilled nurse to become an REI-specific nurse?
A. It's a, it's a long process to make sure that they are fully competent in all of those areas.
Q. How long?
A. Depends on the nurse, but several months.
Q. What's the basis for your understanding?
A. The basis for my understanding is the various nurses who had come into the division and the process by which they were trained. The specifics of that are better left to my nurse manager than me, but, but it was certainly a long onboarding process.
Q. In Exhibit 5 here you say, "My assumption is that MBP will be refocused to GYN ultrasound". Why was that your assumption?
A. Because that's, that is based on my conversations with Dr. DeMars.
Q. When you built this in, this assumption, to the plan, was it your understanding that this was definitely the plan, or was this simply one of the variations that you mentioned Dr. DeMars had spoken to

you about?
A. This was simply one of the variations.
Q. Did you understand it to be the top choice for among those variations?
A. So this is one of the examples that I alluded to earlier today in which I said the information that I would be given by Dr. DeMars that I would move forward on sometimes turned out to not be, I would not have the full context. This is one of those examples. So this plan was based on my conversations with Dr. DeMars.
Q. Did you think that she was telling different things to different people?
A. I don't know.
Q. You mention here the staffing plan for both a complete shutdown and a rebuild. Are those two different alternative plans?
A. I don't remember.
Q. You said that the information you had gotten from Dr. DeMars was the basis for your assumption that Dr. Porter, MBP, would be refocused to GYN ultrasound. Do you know if that plan changed when Dr. DeMars spoke to Daniel Herrick?
A. I don't know.
Q. Do you know what it was that caused that plan to change?

A. I don't know.
Q. Did you hear anything about that?
A. No.
Q. In this process did you ever talk to Dr. DeMars about patient demand for services that Dr. Porter could provide?
A. No.
Q. Why not?
A. What do you mean?
Q. Why not?
A. So my understanding in communications with Dr. DeMars was that much of which, much of the care, particularly surgical care, could be provided by the generalist team. If REI was closing down, then there was no need for that patient care. There were conversations about how we would get patients that care elsewhere.
Q. I see that it's about 3:00 o'clock. Would you like to take a break?
A. I'm doing okay right now.
Q. You're doing okay? Okay. Good. Looking at this document, still Exhibit 5, I see that on the, the second-to-last page with the "Future Staff with Complete REI Shutdown" is the middle column. What do you understand that scenario to be?

A. So I understand this scenario to be the difference between what the division currently looked like with what might happen after the closure if Beth Todd was retained and moved to the generalist division to provide GYN care and Dr. Porter was retained to continue with GYN ultrasound.
Q. Do you know, as of that time, how much of Dr. Porter's time was devoted to GYN ultrasound?
A. My recollection is that most of the time when she was working was devoted to ultrasound.
Q. In that period in 2017?
A. Correct.
Q. And that was, really, that was a generalist service, not REI-specific?
A. I'm, I'm not sure.
Q. Did she -- she looked at ultrasounds. Maybe you don't know. Do you know if she, as part of that GYN ultrasound work, looked at ultrasounds that were not REI-specific?
A. My understanding is that, yes, there was some GYN ultrasound that was not REI-specific.
Q. You mentioned a moment ago that the, the generalists would be able to take over the surgical work that Dr. Porter had done. Did you talk to Dr. Tyler at all, Dr. Regan Tyler, at all about the

that point in time that there were patients scheduled for June and July in addition to May?
A. Yes, but I don't remember what they were scheduled for or where they were in cycle.
Q. Would that have made a difference?
A. A difference to what?
Q. How concerned everybody would be about leaving them hanging.
A. I don't know. I know that the primary concern from my perspective at this point was that we didn't have nursing staff to safely shepherd these patients through.
Q. Were there -- there were no solutions to that, to bring somebody in, other than just closing?
A. Could you rephrase that for me, please?
Q. I'm trying to understand what your position is on there not being nursing staff and the concern for patients in the absence of sufficient nurses.
A. So, at this point, we, Sharon had retired. Casey was no longer with us. Marlene had given her notice. There was one RN who was still not fully trained to manage that division and a couple of LPNs who could do some work, but not near enough that was necessary. So I was concerned the day I heard Marlene was giving her notice that we would not have sufficient trained

nursing staff to be able to appropriately run the REI division.
Q. How far in advance had Sharon given notice of her plans to retire?
A. She gave us significant notice. It was several months.
Q. What was the response to this email in Gunnell Exhibit 7?
A. I don't remember.
Q. Were people confused?
A. I don't remember. I don't remember the response to this specific email.
Q. Did you think that this was appropriate messaging to send out at that point in time?
A. What do you mean by "appropriate messaging"?
Q. In the context of what you knew about what had been decided.
A. I, I don't remember exactly what I was thinking at the time. I, I do remember thinking we need to be thoughtful of about how we roll this out so that we don't leave, leave patients just, just hanging.
Q. Were there discussions about how to time the announcement of the, the announcement of the closure and then the actual closure?
A. Were there, were there discussions on how to time

from the announcement to the actual end?
Q. Yes.
A. Yes.
Q. What were those discussions?
A. I don't remember all of the details of those discussions, and I don't think I was part of all of those discussions either.
Q. Can you tell me about the ones that you were a part of?
A. So I don't remember all of these details. I remember trying to figure out how can we, how can we navigate not having appropriate staff and not being able to provide appropriate care with managing the patients who are currently in cycle and what is it that we can do to, to bridge that gap. So I do remember having those conversations and looking at how many patients that we had in cycle and where they were and, and who, who their provider was. I do remember looking at that.
Q. Who did you talk to about this?
A. I remember talking to Dr. DeMars about it. I don't remember if I spoke to Daniel Herrick about it or not.
Q. How many times did you talk to Dr. DeMars about it?

A. About that specific piece of it, I'm not sure.
Q. How many times do you think you talked to Dr. DeMars about the REI closure in general?
A. Every time I met with Dr. DeMars for three years, we talked about REI, every time, several times a week. So, probably, every time I met with her, we talked about this to some degree or another.
Q. You sound a little frustrated by the amount of time that you spent talking about REI. Is that accurate?
A. That's accurate, yes.
Q. Can you tell me more about that, about the, those feelings of frustration?
A. Yes. It, it was very frustrating, I think, as I said earlier today, the inordinate amount of time spent on managing that division and its complications compared to the scope of my actual job. To some degree, it was frustrating to feel like I'm not likely to be able to solve these problems, because these problems are above my pay grade, and I can't change personalities. And so it was frustrating to feel like I was just spinning my wheels year after year, and it was frustrating to know that the time I was spending with REI could probably be better focused somewhere else in the department.

me that everyone involved in that was leaving.
Q. Did you think that closure was the right decision?
A. At that time, at that time, I hadn't -- you know, I was not in a space to be able to really process it. I was just trying to make sure things happened. In hindsight now, yes, I think that was probably the right decision.
Q. At the time you had had a few weeks to process what was happening, in that time did you have a sense that it was the right thing to be doing?
A. Again, during that time, I was just trying to make sure that things happened, so, so I'm still processing.
Q. It seems in some ways like it was a pretty quick period of time between the decision to close and the announcement. Is that how it feels to you?
A. I think it was a short period of time. However, it, we also didn't have a nurse, right? So, when that, when Marlene gave her notice, it was no longer safe to continue care, and so, from my perspective, the timeframe was likely more around the, the safety of our, of our patients and how to navigate that. So that's the way I see that timeframe.
Q. Did you think it was the right decision to terminate Dr. Porter?
A. Yes.

Q. Why?
A. Because, when we're looking at the dynamics and the dysfunction of that team, she was a central part of that, and I am not convinced that the team, any team would be able to have a healthy dynamic if she was at the center of it.
Q. What if she had been redeployed to do GYN ultrasound?
A. I don't know.
Q. So you said that Dr. DeMars took off in the morning of May 4th. When did she come back?
A. She was headed to a conference, and I don't remember how long the conference was, but it was at least a couple of days.
Q. So let's go back, and, and can you tell me more about the response when you were there making these announcements? What else happened the rest of the day on May 4th?
A. I don't remember. I don't remember. Oh, I do. We spent a fair amount of time communicating with people after the department was made aware of the decision. Then we deployed several people -- I don't remember exactly who -- to start contacting patients to let them know. We wanted patients to hear it directly from us prior to hearing it in the newspaper.

Q. Were you able to contact all of the patients?
A. I believe so.
Q. What was the message that you were giving patients?
A. I don't remember the exact talking points.
Q. Do you remember generally if there was anything that you were supposed to say or not supposed to say?
A. I don't remember.
Q. Were you supposed to tell people that it was because of provider dysfunction?
A. That was not one of the talking points.
Q. Do you think that was the reason for the closure?
A. I don't think it was the whole reason for the closure, no.
Q. But part of the reason?
A. I think that, had we been able to keep and retain and train nurses, we would have kept trying to solve the dysfunction.
Q. I'm sorry. Can you say that again?
A. I think that, had we been able to get nursing staff and keep nursing staff, we would have continued to try to work with that team and overcome the dysfunction of the team.
Q. And the problem there was HR saying that you couldn't continue to recruit nursing staff?

A. I don't think that was the core problem, because we had had issues recruiting nursing long before HR made that decision.
Q. It sounds like there was a nursing shortage throughout the department, right?
A. Throughout the institution.
Q. Throughout the institution? How much worse was it in REI than in the rest of the department?
A. Worse. It was harder to get nurses, and I think particularly because of the, the skill set required and the, the hours required for that division.
Q. You said a little bit ago that you didn't think that any division would be functional with Dr. Porter in it or words to that effect. What's the basis for that statement?
A. So I, I don't think I meant any division. I don't think that we could have brought new people into an REI division with that. I know that, largely, Dr. Porter could be very difficult to work with. So I don't know whether or not it would have been as difficult if it was just ultrasound. I honestly don't know.
Q. What made Dr. Porter difficult to work with?
A. Things with Dr. Porter were very much her way or no way, and it was difficult to find a level of compromise.